FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Original (Hardcopy) Signed By: William A. Prince

(Signature of Agency Head)

SCHIP Program Name (s): Partners for Healthy Children

SCHIP Program Type: _X_ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period: **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date: December 21, 2000

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

These sections have been designed to allow you to report on your SCHIP program's changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility:

   During Federal Fiscal Year 2000, the South Carolina Department of Health and Human Services (SCDHHS) applied federally mandated eligibility changes to the SCHIP program. Those changes, effective 7/1/00, are as follows:

   - The citizenship or immigration status on non-applicants (parents or other household members) is not applicable to eligibility determination.
   - The needs and the income of the ineligible alien are considered in the eligibility determination.
   - Social security numbers for non-applicants (parents or other household members) cannot be required as a condition of eligibility.

2. Enrollment process:

   South Carolina has implemented a modification in application processing which we call assumptive eligibility. For otherwise complete applications, which have income listed at a level that would result in eligibility but are missing the pay stubs or other documentation of income, it is assumed the child is eligible and the case is entered in the Client Information System. The parent receives a letter of approval, but also receives a sequence of notices that they must send required documentation of income within a specified timeframe or the case will be closed. Eligibility is continued if income documentation is received. A notice is sent to close the case if documentation is not received within 30 days. If an assumptive case is closed, eligibility may not be determined using the assumptive process for a period of six months.

3. Presumptive eligibility: **NC**

4. Continuous eligibility: **NC**

1. Outreach/marketing campaigns:

SC Covering Kids had just gotten organized at the end of FFY 1999. During FFY 2000, they went into action. They hired a professional marketer and have provided slick, professional looking brochures and posters, as well as a number of small, promotional items that can be distributed at community events. They also had our Community Resource Guide printed in a usable, attractive format. It has been a valuable resource in training community and faith groups to help identify potentially eligible children and assist parents in completing and submitting the application. Through pilot site projects, they have focused on several hard-to-reach populations with a thoroughness not feasible with only a small state level outreach staff. They have carefully selected outreach staff, often matching staff characteristics to the target populations so they can relate to and be easily accepted by their communities.

SCDHHS continued with most aspects of previous outreach efforts, continuing to emphasize getting copies of the application into the hands of parents of potentially eligible children. The South Carolina Department of Health and Environmental Control (DHEC) continued their outreach through district and county staff. Most usual distribution points were utilized again, and particular emphasis was placed on distribution to all licensed, registered and sponsored childcare facilities. The mass mail-out of applications to schools was not done at the beginning of the school year, however, as that was intended for when the state planned to expand eligibility to 165% of poverty mid-year.

In the fall, bright yellow 3 ½" X 8 ½" PHC flyers for all students were distributed to the schools. These flyers had the PHC logo, name, and toll free number to call for an application. It also noted that if children qualify for Free or Reduced Lunch, they may qualify for PHC. In an effort to target schools with the highest potential number of eligibles first, the flyers were distributed first to districts with the highest number of students on the Free and Reduced Lunch Program, but not on Medicaid.

A list of applications that have been returned to the applicant, excluding those returned because the applicant was already Medicaid eligible, is compiled weekly. Applications are returned to applicants when there is information missing and SCDHHS staff has been unable to reach the applicant by phone. SCDHHS staff first reviews the list to ascertain if cases have been opened on any of the clients in the time lapsed since the list was compiled. Contact information for those who do not have open cases is then sent to the thirteen regional health districts of DHEC. Under a contract with the SCDHHS for the provision of Medicaid outreach, DHEC uses the contact information to follow up with applicants and assist with the SCHIP application process if warranted. During FFY 2000, over 500 cases were referred to DHEC for follow up.

2. Eligibility determination process:

In an effort to eliminate differences in case processing, on-site staff at the SCDHHS adopted the standards adhered to by the South Carolina Department of Social Services (DSS). These guidelines were adopted effective July 31, 2000 and cover the following elements:

- Hours of Operation
- Apply without Delay – Applications are considered effective the day they are date stamped as received by SCDHHS.
- Data Entry
- Standard of Promptness – Eligibility must be determined on the day of receipt or no later than the following day for PHC applications that are complete when received. If contact to follow up on an incomplete application is made but verifications are not received within three days of application date, the case is put in pending status. PHC applications received by SCDHHS must be processed within 30 days from the effective date of application to be consistent with DSS county guidelines.
- Obtaining Verifications – Information needed to complete the eligibility determination must be obtained within 30 days of the date the application is received. If information is not received, the eligibility worker will make two contacts at 15 day intervals requesting required information.
- Notices
- Case Reviews (Redeterminations of Eligibility) – County DSS offices maintain cases and must redetermine eligibility according to the established schedule for PHC.
- Accuracy of Eligibility Determination
- Informing and Referral

The Division of Partners for Healthy Children at SCDHHS did much to streamline the eligibility process during Federal Fiscal Year 2000 by eliminating activities that did not have a direct effect on the eligibility determination process and/or by combining related activities. Two examples are given below:

- New applications are initially reviewed for completeness. This allows complete applications to be processed without delay while efforts to obtain missing information begin simultaneously on incomplete applications.
- The quality control unit was disbanded. The quality control function is now part of the responsibility of the supervisor and lead worker within each work group.

When SCHIP was implemented in South Carolina SCDHHS assumed responsibility for a large part of the eligibility determination process for the new program. Initially, job functions of some existing employees were shifted to accommodate the process. Ultimately, the SCDHHS decided to use contract staff through a personnel service. These staff were provided benefits such as annual leave and insurance in hopes of cutting the high rate of turnover historically experienced with temporary staff. Other problems with the

contractual arrangement remained, however. In an effort to improve

management, twenty-four temporary grant positions were put in place in January 2000. These positions replaced the contract slots and allowed for more consistent personnel guidelines, to include supervision and benefits, among staff.

7. Eligibility re-determination process: **NC**

8. Benefit structure: **NC**

1. Cost-sharing policies: **NC**

2. Crowd-out policies: **NC**

3. Delivery system:

There is still only one HMO - Select Health - available to Medicaid clients in South Carolina. Select Health resumed enrollment October 1, 1999 in the 17 counties where it was offered in FFY 2000. Managed care enrollment remains voluntary.

A major new initiative in dental services began in January 2000. SCDHHS worked in conjunction with the SC Dental Association to increase access to dental services for SCHIP and children's Medicaid. The Dental Association agreed to recruit new dentists to enroll as Medicaid providers and to encourage those already enrolled to accept additional patients. With additional funding from the General Assembly, SCDHHS increased the reimbursement rate to 75% of usual and customary fees.

12. Coordination with other programs (especially private insurance and Medicaid): **NC**

13. Screen and enroll process: **NC**

14. Application

Our application was modified to clarify that questions about citizenship and Social Security Number need only be answered for those individuals applying for benefits. The information is optional for parents. Also, the section on proof of income was expanded from an information statement about the need to submit documentation and description of acceptable documentation to an interactive segment requiring applicants to specify what form of proof they attached. This was done in hopes of receiving fewer applications without proof attached. We also added an opportunity for parents to request that DSS contact them about applying for their own health insurance coverage.

15. Other: **NC**

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   In September 1999, the net addition of children to the state's Medicaid program was over 112,000. By September 2000 that had grown to 142,788 more children with health insurance coverage. Of the total net addition, over 49,000 (35%) were eligible under Title XXI (SCHIP). The remaining 93,000 or 65% were eligible under Title XIX (regular Medicaid), but were enrolled as a consequence of the outreach efforts under Partners for Healthy Children.
   (Date source is internal reports from MMIS on Medicaid Eligible Children under 19 Years Old by County by Month and Report on Payment Category 88. The number of SCHIP eligible children for a month is subtracted from the total number of children under 19 enrolled in Medicaid that month.)

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   Since the beginning of the PHC outreach activities and enrollment simplification, there has been a net increased enrollment of children in the regular Title XIX Medicaid program of over 93,000.
   (Date source is internal reports from MMIS on Medicaid Eligible Children under 19 Years Old by County by Month and Report on Payment Category 88. The number of SCHIP eligible children for a month is subtracted from the total number of children under 19 enrolled in Medicaid that month.)

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   The only other evidence of progress toward reducing the number of uninsured, low-income (<200% of poverty) children can be gleaned from the recently issued CPS data , although that data still is subject to relatively high standard errors. The new three-year average for low-income uninsured children in South Carolina for 1997, 1998, 1999 is down to 128,000 (standard error 23,500). The previous three-year average for 1996, 1997, and 1998 for that population segment was 141,000 (standard error 24,600).

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   _X_ No, skip to 1.3

   ___ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator).
Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the number and proportion of uninsured and under-insured children in the state.	**1.1** Market the PHC program.	**Data Sources:** Internal records and tracking system **Methodology:** Analysis of number of applications distributed, source of applications received, and targeted outreach activities. **Numerator:** **Denominator:** **Progress Summary:** **Applications distributed:** >515,000 (10,000 Spanish and 505,000 English) **Source of applications:** >83,467 received in Central Application Processing (Mail-in) from program inception through 9/30/00; applications also taken at county DSS offices. **Note:** Analysis of Application Source Report omits some applications received before source question was added. See attachment 4 - "Analysis of Application Sources"

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
		Targeted Outreach: See "Outreach" in Section 2.4
OBJECTIVES RELATED TO CHIP ENROLLMENT		
Reduce the number and portion of uninsured and under-insured children in the state.	**1.2** Enroll targeted low-income children in Partners for Healthy Children (PHC).	**Data Sources:** MMIS, CPS & Census; HCFA 64.21E & 64.EC at quarter ended 09-30-00 **Methodology:** Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition. **Numerator:** Net additional number of children in Medicaid/PHC: **142,788** **September 2000** Regular Medicaid = **93,263** SCHIP Medicaid = **49,525** **Denominator:** Baseline number of uninsured below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500. **Progress Summary: 142,788**/162,500 = **87.9**% **(August)** **Note:** Not all retroactive cases have been included in enrollment as of report date, December 12, 2000.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Reduce the number and portion of uninsured and under-	**1.2** Enroll targeted low-income children in Partners for Healthy	**Data Sources:** MMIS, CPS & Census; HCFA 64.21E & 64.EC at quarter ended 09-30-00

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insured children in the state.	Children (PHC).	**Methodology:** Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition. **Numerator:** Net additional number of children in Medicaid/PHC: **142,788** **September 2000** Regular Medicaid = **93,263** SCHIP Medicaid = **49,525** **Denominator:** Baseline number of uninsured below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500. **Progress Summary: 142,788**/162,500 = **87.9**% **Note:** Not all retroactive cases have been included in enrollment as of report date, December 12, 2000.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Establish **medical homes*** for children under the Medicaid/PHC programs. * See attachment 6 for	**3.0** Recruit and orient physicians for participation in HOP, PEP, and HMO programs.	**Data Sources:** Internal program reports **Methodology:** Compare number of Medicaid enrolled practices and primary care physicians participating in medical home programs at 1997 baseline and 2000. Compare number of Medicaid/PHC children enrolled in the HMO and PEP programs and number of children receiving services through a HOP physician practice for baseline 1997 year and 2000. **Numerator:** (2000 Number - 1997 Number)

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
definition of medical home and programs.		**Denominator:** 1997 Number **Progress Summary:** <u>Physicians Participating in Medical Home Programs</u> HMO's (405 - 291)/2 91 = 39.2% Increase PEP (43 - 3)/ 3 = 1333.3% Increase HOP (421 - 40)/ 40 = 952.5% Increase <u>Medicaid PHC Children in Formal Medical Homes</u> HMO's & PEP (33,495- 4,076)/4,076 = 721.8 % Increase HOP (47,007- 528)/528 = 8,802.8% Increase Between FFY 1999 and FFY 2000 there was a 6% decrease in the number of physicians participating in the HMO program, from 431 in 1999 to 405 in 2000. This change is likely related to the fact that during FFY 1999 there were two separate HMO's participating in South Carolina's Medicaid managed care program while only one, Select Health, participated during FFY 2000. In addition, Select Health experienced a decrease in the number of primary care physicians under contract although the HMO continues to have an adequate provider network. Between FFY's 1999 and 2000, the number of enrolled PEP providers remained at 43, and the number of HOP enrolled providers increased 7.7% (from 391 to 421). Since FFY 1999, children enrolled in the HMO and PEP programs increased 235% (from 10,000 to 33,495) and children enrolled in the HOP program increased 291.7%

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		(from 12,000 to 47,007). **Note:** Number enrolled in HOP is likely undercounted due to reliance on sick codes to identify enrolled children.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Increase access to preventive care for PHC children.	**4.1** Immunize pre-school children in PHC at the same rate as age-comparable groups in the general population. * See Attachment 7 for two-year-old immunization coverage survey report. **4.2** Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.	**Data Sources:** South Carolina Department of Health and Environmental Control's (DHEC) "Two-Year Old Immunization Coverage Survey of SC Children 1999" **Methodology:** Compare complete 4313 series* immunization rates for Medicaid/PHC children to those for the general population of two year olds in sample. Medicaid/PHC rate = 89.3% Non-Medicaid/PHC rate = 88.8% **Progress Summary:** Based on DHEC's 1999 immunization coverage survey, rate of series 4313 complete Medicaid/PHC children is .5% higher than the rate of series 4313 complete Non-Medicaid/PHC children. * 4313 series = 4 DTP, 3 Polio, 1MMR, 3 Hib **Data Sources:** HCFA - 416 Reports **Methodology:** Compare percent of PHC/SCHIP children to percent of regular Medicaid children ages 6 - 20 receiving recommended screens. **Numerator:** Number actual screens received**.** **Denominator:** Number expected screens. **Progress Summary:** In SFY 1998, the screening ratio for regular Medicaid dropped below the 1997 baseline. The SCHIP screening ratio of 43% , however, was slightly above Medicaid's 1997 level. There were changes in how South Carolina's EPSDT program was administered and billed in 1999. In addition, the reporting criteria for the HCFA 416

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		changed. The FY 1999 screening ratios calculated for both SCHIP and regular Medicaid were less than earlier years, though the SCHIP ratio of 0.34 was higher than regular Medicaid at 0.27. EPSDT ratios for 2000 will not be available until spring of 2001.
OTHER OBJECTIVES		
Improve access for children to medical care delivered in the most appropriate setting.	**2.1** Decrease the overall percent of Medicaid/PHC children's emergency room visits for non-emergent conditions.	**Data Sources:** MMIS **Methodology:** Compare % of non-emergent ER visits for 1997 baseline and 2000. **Numerator:** Number of non-emergent emergency room visits **Denominator:** Number of emergency room visits **Progress Summary:** In SFY 1997 the percent of Medicaid children's emergency room visits for non-emergency conditions was 13.4%**.** In 1998 it decreased to 4.4% and remained the same in SFY 1999. In 2000 the percent was 4.9%, a very slight increase, resulting in an overall decrease of 63% since the beginning of the PHC program.
	2.2 Decrease uncompensated care delivered to children in hospital settings.	**2.2.1. Inpatient Admissions** **Data Sources:** Office of Research & Statistics, Hospital Discharge Data Set **Methodology:** Compare % children's inpatient admissions without insurance as pay source for 1997 baseline and 2000. **Numerator:** (% for 1997 - % for 2000) **Denominator:** % for 1997 **Progress Summary:** In SFY 1998, the percent of children's inpatient admissions without insurance as the expected pay source, dropped to 4.5%, a decrease of almost 20%. In SFY 1999, the percent dropped to 3.5%, another 20% decrease. In SFY

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Improve management of chronic conditions among PHC enrolled children.	**5.0** Decrease the incidence of children hospitalized for asthma among Medicaid/PHC enrolled children by 2%.	2000, however, it increased to 4.0%, up 15% over the previous year. This constituted an overall decrease from the baseline of 27%. **2.2.2. Emergency Room Visits** **Data Sources:** Office of Research & Statistics, Emergency Department Data Set **Methodology:** Compare % children's emergency room visits without insurance as pay source for 1997 baseline and 2000. **Numerator:** (% for 1997 - % for 2000) **Denominator:** % for 1997 **Progress Summary:** In SFY 1998, the percent of children's emergency room visits without insurance was 18.8%, representing almost a 9% decrease. In SFY 1999, it had dropped to 15.0%, a decrease of about 20%. In SFY 2000 it dropped another 15% to 12.7%. Overall, the percent of uncompensated care for children's visits to the emergency room has decreased by 38% from the baseline. **Data Sources:** Office of Research & Statistics **Methodology:** Compare incidence rates for State fiscal years (SFY) 96/97& 97/98, 97/98 & 98/99, 96/97 & 98/99, and 98/99 & 99/00 to calculate percent change. **Numerator:** (1^{st} year rate - 2^{nd} year rate) **Denominator:** 1^{st} year rate **Progress Summary:** From SFY 96/97 to SFY 97/98, the rate decreased 7%; from SFY 97/98 to SFY 98/99, the rate decreased 20%; from SFY 96/97 to SFY 98/99, the rate decreased a total of 26%.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Strategic Objective 1:
Reduce the number and proportion of uninsured and under-insured children in the state.

Performance Goal 1.1: Market the Partners for Healthy Children (PHC) insurance program.

Performance Measures:

- Applications Distributed

Barriers:
In the first few months of 2000, it was not clear how much of the budget deficit in the Medicaid program would be covered by legislative appropriations and applications were not printed as readily as in past years. Starting in May, applications were mailed en mass to most distribution organizations used in previous years of PHC; SCDHHS did not do a mass mail-out of applications for every student to each school this year. Applications were sent for each child, however, to all Head Start and child care facilities. SCHIP staff has coordinated all requests for applications by groups and organizations that plan to distribute. If schools requested applications to distribute, staff filled those requests. Bright yellow flyers (with PHC name, logo, toll free number and notation that children eligible for free or reduced school lunch may be eligible for PHC) were sent to all schools for distribution to each student. It was intended that school distributions of applications would be timed to coincide with an expansion of eligibility to 165% of poverty and be phased in throughout the remaining school year to avoid large fluctuations in the number of applications received. The expansion was planned for January 2001, but has been postponed indefinitely due to an overall Medicaid budget deficit and projected slowdown in collection of state revenues.

- Targeted Outreach

Barriers:
Targeted outreach efforts continued, with emphasis on harder to reach populations. Covering Kids sites concentrated on Hispanic children, adolescents and rural residents. Planned coordination with a couple of the Historically Black Colleges and Universities to utilize students for outreach to surrounding rural areas was delayed in start-up. Additional training was planned within the faith community, particularly those denominations with high numbers of minority members, but the departure of a key African-American bishop slowed progress.

Performance Goal 1.2: Enroll targeted low income children in Partners for Healthy Children (PHC)

Barriers:
There had been anecdotal reports of barriers perceived by the Hispanic population, many of which we hope have been addressed by changes in the application regarding questions about Social Security Number and citizenship, focused efforts by Covering Kids to identify "best practices" for this population, and wider dissemination of Immigration and Naturalization Service (INS) policy regarding public charge. SCDHHS had the Spanish version of the application translated by the HABLA Project at the University of South Carolina because they utilize combined efforts of four translators from different geographic and cultural backgrounds. Even with this translation, however, we have still received a few comments about "inaccuracies", demonstrating the difficulty in devising a single version appropriate for all the Hispanic populations. The telephone translation service (Language Line) has improved services of the toll free line for non-English speakers. On average, this service is used about four times per month, with average time per month of 36 minutes.

South Carolina chose to cover older teens under SCHIP rather than accelerate regular Medicaid coverage for them. Since an additional age cohort receives regular Medicaid coverage each October 1st, this results in an SCHIP enrollment anomaly. Each October the SCHIP enrollment dips as the new age cohort under 100% of poverty is shifted to regular Medicaid.

Strategic Objective 2:
Improve access for children to medical care delivered in the most appropriate setting.

Performance Goal 2.2: Decrease uncompensated care delivered to children in hospital settings.

Performance Measures:

- Percent of children's inpatient admissions without insurance as expected pay source.

Barriers:
None noted; Performance Goal met. Although there was a small up-turn in uncompensated care for children's inpatient admissions it is anticipated this measure will remain low as more children are enrolled in SCHIP and regular Medicaid.

- Percent of children's emergency room visits without insurance as expected pay source.

Barriers:
None noted; Performance Goal met.

Strategic Objective 3:

Establish medical homes for children under the Medicaid/PHC programs.

Performance Goal 3: Recruit and orient physicians for participation in HOP, PEP, and HMO programs.

Performance Measures:

- Number of Medicaid enrolled practices and primary care physicians participating in medical home programs.
- Number of Medicaid/PHC children enrolled in the HMO and PEP programs.
- Number of children receiving services through a HOP physician practice.

Barriers:
Performance Goal met previously, however, a large portion of the physicians who could participate in the medical home programs have now heard about the programs or been contacted, so growth has slowed considerably. DHEC still continues to recruit physicians for Medicaid enrollment and increased participation levels and their staff advocates for the medical home programs in particular. HMO enrollment has been growing after the Select Health HMO was reinstated and allowed to begin recruiting clients and expanding into new counties.

Strategic Objective 4:
Increase access to preventive care for PHC enrolled children.

Performance Goal 4.1: Immunize pre-school children enrolled in PHC at the same rate as age-comparable groups in the general population.

Performance Measure:

- Percent of pre-school children enrolled in PHC and regular Medicaid receiving all recommended immunizations at ages 2 and 5 years.

Barriers:
The percent of Medicaid/PHC two-year olds with a complete immunization series compares favorably with that of the same age cohort in the general population. The DHEC immunization data collection system, named the Statewide Immunization Information System (SIIS), originally intended for use when the Performance Goal was developed has been completed. Integration of the system into the health care community is currently under way. Health district teams have been trained to install the software in private physicians' offices and a number of private practices are online. Equipment is being fine-tuned to improve the slow response time and DHEC staff expects the system to be fully operational in the near future. Data from the system is currently available through requests to DHEC's IT Department.

SIIS is in the early stages of being populated with Medicaid data, therefore, information for FFY 2000, information from the sample study of two year olds done by DHEC has been reported in this document. In the future, using data collected in the SIIS, SCDHHS expects to be able to compare immunization rates of Medicaid eligible children with rates of the non-Medicaid population on a regular basis.

The goal has been modified to: "Immunize two year old children enrolled in PHC at the same rate as two year olds in the general population." The measure will become percent of two year olds enrolled in PHC and general population receiving all recommended immunizations. The measurement for 5 year olds will probably not be pursued since complete immunizations are required for first grade entry.

Performance Goal 4.2: Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.

Performance Measure:

- Percent of SCHIP and regular Medicaid children ages 6 - 20 eligible for screening who receive recommended EPSDT screenings.

Barriers:
Because we already are considerably more successful in screening children under 6 and most of the children in our targeted expansion group are over age 6, we have chosen to concentrate on children ages 6 - 18 in this measure. We will continue current efforts to screen those under 6. For older children, the recommended screening schedule does not include a screening every year. Also, it is more difficult to get older children to comply with recommended screenings, as evidenced by the baseline numbers for current Medicaid eligibles aged 6 - 20. All these factors have influenced the target selected for this measure. The HCFA 416 data showed screening ratios for 1999 continued to decline. There were changes in how the SC EPSDT program was administered and billed in 1999, in addition to reporting criteria for the 416 report. SCDHHS needs to investigate other reasons for this continued decline and, if it is not related to reporting criteria or similar changes, develop strategies to remedy.

Strategic Objective 5:
Improve management of chronic conditions among PHC enrolled children.

Performance Goal 5: Decrease the incidence (# per 1000 children) of children hospitalized for asthma among Medicaid/ PHC enrolled children through identification and dissemination of effective patient education and disease management strategies to physicians.

Performance Measure:

- Incidence of children's inpatient admissions for asthma.

Barriers and Future Plans:
Performance Goal met previously. Use of the emergency room and inpatient hospitalizations should not be necessary if asthma is properly controlled. Efforts will continue to drive down hospitalizations and to decrease use of the emergency room as well.

1.5.1 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

NA

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

SCDHHS will focus more attention on the EPSDT rates in order to identify reasons for the declines. The agency will investigate reporting/systems contributors as well as addressing the rates as measured. Staff will begin to develop education strategies to increase rates if that is appropriate.

The agency will continue to monitor progress in getting the Statewide Immunization Information System operational. Hopefully it will begin producing data in time for the next report.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

1. New Standards for Application Processing
2. PHC flyers sent to schools
3. New PHC applications (English and Spanish)
4. Source of Applications Report and County Activity Summary
5. PEP Enrollee Status Report
6. Enrolled HOP Providers
7. Medical Home Definition and Programs
8. Two-Year-Old-Immunization Coverage Survey of South Carolina Children 1999
9. Dis-enrollee Survey

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: Not Offered.

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults:_____
   Number of children:_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: Not Offered.

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults:_____
   Number of children:_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

   At our eligibility level of 150% of poverty, crowd-out is not a particularly worrisome concern. If an income eligible family has health insurance at the time the application is submitted, the children are eligible under Title XIX rather than XXI. Even if there is health insurance, the benefit structure is usually inferior to Medicaid in providing such things as well child care and screenings for vision, hearing, and developmental progress. South Carolina doesn't want to encourage families to drop existing coverage in order to be eligible for more comprehensive services and prefers to provide wrap around coverage to supplement existing benefits.

2. How do you monitor and measure whether crowd-out is occurring?

   The application asks for information about any health insurance coverage the family already has and verifies that information with employers and record matches under regular Medicaid TPL procedures. The state also looks at the number of recipient children who would have been SCHIP eligible, but were enrolled under Title XIX because they had insurance coverage.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

   In September 2000, there were 3,809 recipients who would have been SCHIP eligible but were in the category of expansion children—regular match because they had insurance.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

   South Carolina has not done any studies regarding effectiveness of crowd-out strategies.

2.4.1 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children?

Making the simple applications available from commonly visited locations and getting applications into the hands of parents of potentially eligible children has been most effective. South Carolina has a simplified application, which is reader friendly and simple to complete. The application offers a toll free telephone number where potential recipients can get assistance and the address where the application can be mailed. Clients voice positive comments about the quick turn around time in processing applications for approval within a two week time period.

2. How have you measured effectiveness?

Word of mouth continues to be a very popular means of awareness for low-income population.

3. Have any of the outreach activities been more successful in reaching certain populations?

South Carolina has concentrated on building numerous partnerships with organizations at the grassroots level. These organizations have participated enthusiastically and effectively in identifying potentially eligible children, making sure their parents get an application, and some assist in completing the application.

The organizations below are instrumental in reaching target populations.

Day cares: Alliance for SC's Children, SC Head Start, First Steps, Stand for Children, and HOPE for Kids.

Children/Low income housing: Family Connection of South Carolina, South Carolina Covering Kids, SC Head Start, Low County Healthy Start, HOPE for Kids, Drew Park, Saxon Homes & Hyatt Park.

School aged children: Family Connection of South Carolina, South Carolina Covering Kids, Alliance for SC's Children, United Way of SC, Stand for Children, Community Health Alliance, First Steps, SC Association for Rural Education, American Academy of Pediatrics, Lexington School District, Housing Authorities, Palmetto Youth Partnership, Healthy Schools/Healthy South Carolina Network and St. Francis Health System.

Hispanic: South Carolina Covering Kids, Catholic Charities, Hispanic Outreach Center and SC Head Start.

4. **How have you measured effectiveness?**

The number of partners that have joined in this effort has increased since the inception of this program.

5. **Which methods best reached which populations?**

Partnerships with state agencies, rural health centers, and schools yield the best method for disseminating and receiving completed applications.

6. **How have you measured effectiveness?**

The number of completed applications received is our best indicator of success.

Summary of outreach initiatives for FY 2000

American Medical Association
Family Connection Conference
Columbia Jr. College
Tri-Care
South Carolina Covering Kids
Alliance for SC's Children
Family Connection of SC
SC Christian Action Council
SC Head Start
United Way of SC
Stand for Children
Jasper County Student Services
Low County Healthy Start Resource Forum
Community Health Alliance in Greenville
South Carolina Chapter: American Academy of Pediatrics
Lexington School District 1
March of Dimes
Hyatt Park, Back to School Bash
Saxon Homes Housing Authority
Palmetto Youth Partnership
Children's Defense Fund
Drew Park Health Fair
HOPE for Kids
Spartanburg County Elementary School District 2
Healthy Schools/Healthy South Carolina Network
Make a Difference Day
    HOPE for Kids
    March of Dimes
Peoples Pharmacy Health Fair
SC School Nurse Association
St. Francis Health System
Hispanic Outreach Center
First Steps
Historically Black Colleges & Universities
SC Association for Rural Education
Catholic Charities

Mass mail-out Applications: Day cares, primary care physicians, pharmacies, and hospitals

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

   DSS has instituted pre-closure outreach efforts targeting families of deemed babies – those babies who received eligibility for their first year of life via Optional Coverage for Women and Infants (OCWI). A simplified one-page determination form specific to deemed babies is mailed to families when their child is nine months old. This provides a three-month window prior to the end of a baby's eligibility under OCWI during which families can return the requested information and the caseworker can process the case. If the family has not responded to the initial contact by the baby's 11th month, DSS staff will make a second attempt to secure the necessary information. This second contact may be made by phone or by mail, depending on the circumstances of the case. In some counties, if the family still does not respond and the baby's case is closed, DSS coordinates with the local or district DHEC for outreach.

   In addition, children approved for Medicaid/SCHIP are given continuous eligibility for one year. In effect, even if circumstances change to the degree that they would have caused a case to be closed in the past, children now retain their Medicaid coverage throughout the one-year period of eligibility.

   What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

X	Follow-up by caseworkers/outreach workers
X	Renewal reminder notices to all families
___	Targeted mailing to selected populations, specify population _____
___	Information campaigns
___	Simplification of re-enrollment process, please describe _____
X	Surveys or focus groups with dis-enrollees to learn more about reasons for dis-enrollment, please describe (See # 5. below.)
___	Other, please explain_____

2. Are the same measures being used in Medicaid as well? If not, please describe the differences.

   Yes, Medicaid is the same.

3. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Continuous eligibility is most effective. Another systems change was also effective. Earlier in the program, we found that many children were dropping from enrollment when they turned one year old. Procedures were changed so that reminders were issued to the parent at several points before their child's birthday and cases were not closed automatically.

4. What do you know about insurance coverage of those who dis-enroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   Based on a small study of PHC dis-enrollees (which includes both SCHIP and regular Medicaid children), done in the summer of 2000, 45% of those dis-enrollees have no insurance. Almost as many, however, have obtained insurance coverage through their parents' work (43%). The small remainder left the state, didn't respond, or had only dental coverage.

   Those who had insurance generally had coverage or doctor sick visits, hospitalizations, ER, and drugs. Dental was covered for 87%, but well-child, eye care, and other therapies were covered for only a little over half.

   A copy of the study is attached. The sample was small and drawn from a single month and the response rate was only 28%, so results should be viewed accordingly.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and re-determination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   South Carolina's SCHIP is a Medicaid expansion so all the same procedures are used.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

   The system utilizes indicators such as age and poverty level to determine whether a child is SCHIP or Medicaid. If an indicator is changed, the system counts them correctly as SCHIP or Medicaid. There is no "transfer".

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Yes the delivery systems—managed care, partially capitated and fee for service—are the same for Medicaid and SCHIP.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   South Carolina does not charge premiums or enrollment fees.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   South Carolina does not apply cost-sharing.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

   Performance goals are used to monitor several aspects of quality of care. One of our performance goals is focused on appropriate use of the ER and another on making sure as many children as possible have medical homes. Both are proxies for aspects of quality care. A child with a medical home receives comprehensively coordinated care (primary, preventive, and specialty) with better continuity and access. Encouraging use of the ER for emergencies and not for primary care utilizes resources more efficiently and results in primary care being provided in a more appropriate setting. South Carolina PHC appears to be doing well on these two performance goals. EPSDT screening rates are the focus of another performance goal. Information on these rates can be found in Table 1.3 and in # 2 below.

   The primary study addressing quality of care was submitted with the March 2000 Evaluation. It was "A Utilization Focused Evaluation of the Children's Health Insurance Program (CHIP) of the State of South Carolina Under Title XXI of the Social Security Act," September 1999, pgs.38-42, indicate that the quality of services received is very good. On a scale of 0 to 10, families rated the quality of health care as 8.7 and 42% rated the healthcare received by their child as a ten. Sixty-two percent of Medicaid respondents said they always saw the health professional they wanted to see. Almost 80% said the medical staff is always courteous. Over seventy percent responded that their child's doctor always listens to them and explains things to them. A slightly lesser percent, but still over 60%, felt that the doctor always spent enough time and knew their child's medical history. Almost 85% reported always being involved in decisions. A little over 70% reported that their child got needed

tests. More than 90% said there was no problem getting needed referrals and over half whose child was referred said the doctor definitely knew the results of the referral.

When asked whether their healthcare provider had discussed basic preventive health issues with them, parents indicated that 86% had discussed immunizations, 80% nutrition and rest, 69% home safety, 67% normal child development, and half had discussed how to handle behavior problems. Parents of children under six were asked about age-relevant issues discussed with them. Seventy percent had discussed WIC, but only 56% had mentioned EPSDT. Discussion of using child safety seats was high at 79%. Parents of older children were asked different questions. Over half reported use of seatbelts, bicycle helmets, and keeping children away from guns being discussed. Please see the previously submitted report for more details.

The PHC Dis-enrollee Survey also asked a few questions about customer satisfaction. Overall the response was 'good', with minimal negative comments. Only 3% of the respondents were dissatisfied with the quality of services and care received. Of those responding, 94% were either very satisfied or satisfied with the quality of service their child received from participating hospitals, clinics or dental offices. About the same percentage (95%) were either very satisfied or satisfied with the quality of care received from his/her doctor or nurse in the PHC program.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   The primary focus of quality of care monitoring for the fee-for-service segment of SCHIP enrollees is contained within the performance goals and measures. Factors such as medical homes, immunizations, and screenings are covered. Plans for more in-depth study are outlined in #3 below.

   For SCHIP children enrolled in managed care, there is more systematic, on-going monitoring of quality. In addition to client satisfaction surveys and complaint/grievance reviews, there are case file reviews, independent peer reviews, and HEDIS performance measurements.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

   SCDHHS plans to contract with the Camcare Health Education and Research Institute for a study on medical care utilization among children enrolled in the South Carolina Medicaid program. A three-year time period, July 1, 1996 thru June 30, 1999, will be covered by the study. The broad target population of Medicaid eligible children will be broken down into coverage categories, including SCHIP, and the research questions will be applied independently to each category. A completion date for the study is not yet available.

   One aspect of the study will focus on quality of care issues. Relative to quality of care, the following

items are being considered for study:

1) Are Medicaid enrolled children receiving appropriate primary care?

- What percentage of children is receiving recommended preventive services?
- What percentage of children is receiving treatment that follows recommended protocols for chronic disease management, for acute illnesses, and for injuries?

2) Is the emergency room being utilized appropriately? (i.e., not for primary care)

3) Are there differences by geographic region in the appropriateness of services provided?

4) If appropriateness of care varies by region and/or coverage category, are these differences related to variations between the regions in:

- Demographic characteristics of the children in the program (e.g., age, sex, race)
- Health problems of the children (e.g., more chronic conditions in a region compared to other regions)
- Setting where care is provided (e.g., more emergency room use, less ambulatory care)
- Physician group characteristics (e.g., size of group, specialty mix)
- Hospital characteristics (e.g., ownership).

Ideally the results of the study will provide a framework for use in improving access and quality of care for children enrolled in the South Carolina Medicaid program.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility:

   Although budget problems have been a barrier to expanding the eligibility level for PHC, and will continue to be within the next budget cycle, there have been changes to the eligibility process that constitute improvements for applicants. Assumptive eligibility allows children to begin receiving benefits while missing income documentation is being furnished. New processing standards have increased the efficiency and timeliness of the process. Changes to require sensitive information such as SSN and citizenship only from applicants for benefits should have removed some barriers for immigrant parents.

2. Outreach:

   Work with grassroots community groups and a wide range of providers has continued to contribute to the success South Carolina has had in enrolling children in both SCHIP and regular Medicaid. SC Covering Kids has begun to play an important role in outreach and has structured its contributions to compliment those of other players in the outreach process. DHEC and DSS continue to make major contributions to the outreach effort.

3. Enrollment:

   SC children's Medicaid has seen a net increase in enrollment since the beginning of PHC of over 142,000, with more than 49,000 of them being SCHIP. About 29,000 of the increase have taken place in the last Federal Fiscal Year. SCHIP has experienced a much smaller proportion of growth in the last FFY, largely due to shifting of children from SCHIP to regular Medicaid in October and a smaller shift that occurs in March when the Federal Poverty Level changes.

4. Retention/dis-enrollment:

   Dis-enrollment rates on the HCFA 64.21E have increased over the last year, indicating there may still be unidentified barriers within that process. SC Covering Kids, DSS and SCDHHS will be working jointly to identify any barriers and develop appropriate solutions over the next year.

5. Benefit structure: NA

6. Cost-sharing: NA

7. Delivery systems:

   A major new initiative in dental services began in January 2000. SCDHHS worked in conjunction with the SC Dental Association to increase access to dental services for SCHIP and children's Medicaid. The Dental Association agreed to recruit new dentists to enroll as Medicaid providers and to encourage those already enrolled to accept additional patients. With additional funding from the General Assembly, SCDHHS increased the reimbursement rate to 75% of usual and customary fees.

   As a result of this initiative, provider enrollment increased by 33%, from 619 to 824. The expenditures for dental care for SCHIP children increased by 88%, from $2,944,801 in SFY 1998-99 to $5,539,096 during SFY 1999-2000. SCHIP recipients rose from 19,580 to 21,826 over the same timeframe. Among all Medicaid recipients under 21, the number of recipients increased from 115,394 in SFY 1998-99 to 126,349 in SFY 1999-2000 and dental expenditures increased from $18,631,402 to $36,939,816, a 98% increase.

8. Coordination with other programs: NA

9. Crowd-out: NA

10. Other: NA

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments	481,076	528,261	528,261
Managed care			
Per member/per month rate X # of eligibles			
Fee for Service	55,889,957	61,371,739	61,371,739
Total Benefit Costs	56,375,051	61,900,000	61,900,000
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	56,371,051	61,900,000	61,900,000
Administration Costs			
Personnel	1,014,591	1,016,716	1,016,716
General administration			
Contractors/Brokers (e.g., enrollment contractors)	483,125	484,137	484,137
Claims Processing			
Outreach/marketing costs			
Other	597,895	599,147	599,147
Total Administration Costs	2,095,611	2,100,000	2,100,000
10% Administrative Cost Ceiling	6,263,450	7,111,111	7,111,111
Federal Share (multiplied by enhanced FMAP rate)	46,171,122	50,758,400	50,265,600
State Share	12,295,540	13,241,600	13,734,400
TOTAL PROGRAM COSTS	**58,466,662**	**64,000,000**	**64,000,000**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_X_ State appropriations
___ County/local funds
_X_ Employer contributions
___ Foundation grants
_X_ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

NO

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	Partners for Healthy Children	
Provides presumptive eligibility for children	__X__ No ____ Yes, for whom and how long?	____ No ____ Yes, for whom and how long?
Provides retroactive eligibility	____ No __X__ Yes, for whom and how long? 3 months	____ No ____ Yes, for whom and how long?
Makes eligibility determination	__X__ State Medicaid eligibility staff ____ Contractor ____ Community-based organizations ____ Insurance agents ____ MCO staff __X__ Other *(specify):* PHC Central Processing Unit for mail-in applications	____ State Medicaid eligibility staff ____ Contractor ____ Community-based organizations ____ Insurance agents ____ MCO staff ____ Other *(specify)*:
Average length of stay on program	Specify months	Specify months
Has joint application for Medicaid and SCHIP	____ No __X__ Yes	____ No ____ Yes
Has a mail-in application	____ No __X__ Yes	____ No ____ Yes
Can apply for program over phone	__X__ No, but there is a toll free number for assistance	____ No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	____ Yes	____ Yes
Can apply for program over internet	__X__ No, but a form can be downloaded, printed, completed, and mailed in. ____ Yes, for whom and how long	____ No ____ Yes
Requires face-to-face interview during initial application	__X__ No ____ Yes	____ No ____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__X__ No ____ Yes, specify number of months. What exemptions do you provide?	____ No ____ Yes, specify number of months: _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	____ No __X__ Yes, specify number of months: <u>12</u> Explain circumstances when a child would lose eligibility during the time period. Eligibility is terminated at age 19.	____ No ____ Yes, specify number of months: _____ Explain circumstances when a child would lose eligibility during the time period.
Imposes premiums or enrollment fees	__X__ No ____ Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify): _____	____ No ____ Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify): _____
Imposes co-payments or coinsurance	__X__ No ____ Yes	____ No ____ Yes
Provides preprinted redetermination process	__X__ No ____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	____ No ____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

While the initial application can be mailed in to the SCDHHS central processing unit or can go through the local DSS office, all re-determinations are done by the local DSS offices. Prior to the date of re-determination, a series of notices are sent to the parent(s) along with a one page front-and-back form to be completed and returned. For SCHIP re-determinations, DSS has begun using the PHC application form for re-determination. Another difference is that, at re-determination, information that remains constant—like SSN—is not re-verified.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?

If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher:

_____ 185% of FPL for children under age 1 _ __
_____ 133% of FPL for children aged 1 - 5
_____ 100% of FPL for children aged 6-16 ___
_____ 50% of FPL for children aged 17-18 _ __

Medicaid SCHIP Expansion:

_____ 150%of FPL for children aged 1-18
_____ % of FPL for children aged ____
_____ % of FPL for children aged ____

State-Designed SCHIP Program:

_____ % of FPL for children aged ____
_____ % of FPL for children aged ____
_____ % of FPL for children aged ____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions do each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter NA.*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X_ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$100/mo/ working parent	$100/mo/ working parent	$
Self-employment expenses	$* varies	$* varies	$
Alimony payments Received	$ NA	$ NA	$
Paid	$ NA	$ NA	$
Child support payments Received	$50/mo	$50/mo	$
Paid	$ amount paid	$ amount paid	$
Child care expenses	$ 200/mo/child under 12 years	$ 200/mo/child under 12 years	$
Medical care expenses	$ NA	$ NA	$
Gifts	$ NA	$ NA	$
Other types of disregards/deductions (specify)	$	$	$

*** Conforms to IRS rules except depreciation, entertainment travel, meals and contribution expenses are not allowed.**

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups (children)	_X_ No	____Yes; specify countable or allowable level of asset test _____
Medicaid SCHIP Expansion program	_X_ No	____Yes, specify countable or allowable level of asset test _____
State-Designed SCHIP program	____ No	____Yes, specify countable or allowable level of asset test _____
Other SCHIP program_____	____ No	____Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2000? ____ Yes _X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage: NA

2. Employer sponsored insurance buy-in: NA

3. 1115 waiver: NA

4. Eligibility including presumptive and continuous eligibility: NA

5. Outreach:

   We plan to do more targeted outreach, focusing on healthy teens, pre-schoolers, and the Hispanic population. The program appears to be particularly attractive to teenagers who are high utilizers of behavioral and other health services. Targeting healthy teenagers for outreach and enrollment should help us normalize the enrollment for that age group. Dis-enrollment among the pre-school age group has been higher than for other ages, so we need to target them for increased outreach to re-enroll those who did not complete the re-determination process but still met eligibility criteria. Hispanics constitute a growing segment of this state's population and tend to have insurance rates considerably lower than other segments of the population. There is also some evidence that they are more reluctant to apply for public programs, such as PHC, and may benefit from special emphasis for outreach.

6. Enrollment/re-determination process:

   The enrollment process appears to be working well, but dis-enrollments have been growing. While there are legitimate explanations for why some children are dis-enrolled after their continuous eligibility expires, such as increased income or moving from the state, there appear to be too many who are dropped because their parents fail to complete the re-determination process. SCDHHS, Covering Kids and DSS will be examining this process in South Carolina to identify barriers and institute appropriate remedies during the next year. In addition, SCDHHS and several other states with similar concerns are participating in a joint effort coordinated by NASHP to identify "best practices" being used by other states to cope with this problem.

7. Contracting: NA

8. Other: NA